REQUEST FOR FUNDING
FOR THE PROVISION OF ONE-TO-ONE SPECIAL SERVICES

*** * * * * SEE REVERSE SIDE FOR INSTRUCTIONS * * * * ***

THIS CRITERIA MUST BE MET BEFORE PROCEEDING

QUALIFYING ELIGIBILITY CRITERIA FOR ONE-TO-ONE SPECIAL SERVICES

NOTE: Client must meet the current criteria listed below and must also have met the criteria for Therapeutic Behavioral Services (TBS) before age 21. Please note that the criteria noted here are in summary form. See DMH Letter No.: 99-03 and DMH Information Notice No.: 04-05 for more detailed information (www.dmh.ca.gov).

CURRENT ELIGIBILITY CRITERIA:

1. Full-scope Medi-Cal beneficiary
2. Meets MHP medical necessity criteria
3. Between the ages of 21 and 25
4. Member of certified class for TBS except for age

Service need ***(check one)***

- ☐ To prevent placement in a higher level of care
- ☐ To enable transition to a lower level of care

PRIOR ELIGIBILITY CRITERIA

1. Full-scope Medi-Cal beneficiary under age 21
2. Met MHP medical necessity criteria
3. Member of the certified class for TBS

Service need ***(check one)***

- ☐ To prevent placement in a higher level of care
- ☐ To enable transition to a lower level of care

1. Client Mental Health Record Number _____

2. Medi-Cal Provider Number _____

3. Date of Birth (MM-DD-YYYY)
___ ___ - ___ ___ - ___ ___ ___ ___

4. Race/Ethnicity ***(check one)***
   - ☐ White
   - ☐ African-American
   - ☐ Hispanic
   - ☐ Asian/Pacific Islander
   - ☐ Native American
   - ☐ Other (specify)

5. Gender ***(check one)***
   ☐ Female ☐ Male

Retroactive Claim

6. Hours of Service Provided _____

7. Date Service Started ___ ___-___ ___-___ ___ ___ ___

8. TBS Contract rate per hour _____

9. Date Service Ended ___ ___-___ ___-___ ___ ___ ___

Preauthorization Claim

10. Planned Average Hours of Service Per Week _____

11. Estimated Number of Weeks _____

12. Amount of Funds Requested $_____

13. Form Completed Date (MM-DD-YYYY) ___ ___ - ___ ___ - ___ ___ ___ ___

14. Form Completed by (Print Name)_____ Phone (_____) _____

I certify that the above named client and the Special Services that were delivered (in the case of a *Retroactive Claim*) or are to be delivered (in the case of a P*reauthorized Claim*) meet the service requirements in DMH Letter No.: 99-03, except that the client is now age 21 through 25, and that the client met or would have met those requirements when he or she was under age 21. I further certify that all the information reported on this *Request for Funding Form* is complete and accurate.

Signature _____

Title _____

REQUEST FOR FUNDING
FOR THE PROVISION OF ONE-TO-ONE SPECIAL SERVICES

FORM INSTRUCTIONS

GENERAL INFORMATION

Send completed forms to: Bill Carter; California Institute for Mental Health, Cathie Wright Technical Assistance Center (CIMH/CWTAC); 2030 J Street; Sacramento, CA 95814 or fax to Mr. Carter at (916) 446-4519.

READ ALL ELIGIBILITY CRITERIA INFORMATION BEFORE CONTINUING TO COMPLETE THE ENTIRE FORM. IF CLIENT DOES NOT MEET THE ELIGIBILITY CRITERIA, DO NOT REQUEST THESE FUNDS.

All fields must be completed. Please contact Bill Carter at (916) 556-3480, ext. 130 if you have any questions.

If the form is handwritten, please make sure the handwriting is legible. Below are instructions on items that may not be self-explanatory. Some items allow multiple responses; all that apply should be checked. Other fields require just one response. Please be sure to read each item carefully.

Within 14 days of receipt of a request for a retroactive claim, CIMH/CWTAC will approve the retroactive claim and distribute the funds, deny the request or request further information from the provider. Preauthorization claims will be approved or denied or further information requested within 14 days of receipt of the request.

QUALIFYING ELIGIBILITY CRITERIA FOR ONE-TO-ONE SPECIAL SERVICES

Please note that the client must meet the current eligibility criteria for Special Services and must also have met the eligibility criteria for TBS before age 21. However, there is no requirement that the youth has actually received TBS or have been incorrectly denied TBS prior to age 21. PLEASE NOTE: Because Special Services are not a Medi-Cal benefit, youth can qualify even if they reside in an Institution for Mental Disease. Please see DMH Information Notice No.: 04-05 for more information.

CERTIFICATION

Providers must certify that the one-to-one Special Services to be provided meet the service criteria outlined in the DMH Letter No.: 99-03 and DMH Information Notice No.: 04-05. Providers must also certify that the youth met or would have met the service criteria when under age 21. A provider may certify that a child met the service need for TBS when under age 21 based on documentation that he or she did not receive TBS during a time period when the youth was placed in or remained in a higher level of care. Providers do not need approval from the Mental Health Plan (MHP) to submit a claim.

FUNDING

Funding for these special services will be distributed by CIMH/CWTAC in accordance with the stipulations in the United States District Court's Amendment of Judgment and Permanent Injunction for Emily Q. v. Bontá, dated April 22, 2004. CIMH/CWTAC will distribute the funds directly to providers on a first-come, first-serve basis until the fund is exhausted. No claims for these Special Services funds will be reimbursed after the fund has been depleted. Funding for these services is State General Funds. No federal funding is allowable for these services. These services are not to be considered a Medi-Cal benefit. The maximum claim, which can be distributed for services provided to any one youth, cannot exceed $100,000.

ADDITIONAL REQUIREMENTS

Item 1. The Mental Health Record Number needs to be a unique identifier, but cannot be a Social Security Number.

Items 6-11. Funds for services may be requested in advance. Preauthorization may be granted, in which case corresponding funds will be held in reserve for up to, but not exceeding three months of services. The provider will have an additional three months to submit a second form certifying that services have been provided by completing the "retroactive" claim items 6-9 and submitting the Form for payment. At that time the provider will be reimbursed.

The TBS contract rate and the total amount of reimbursement requested may not be higher than the amount that the provider would be reimbursed by the county MHP for the same services had the youth been under age 21.

All information certified on this form is subject to verification.